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Original Department.

Communications.

THE PATHOGENY OF STRABISMUS.

By Dr. F. C. Donders,

Of Utrecht.

Translated from Archiv für Ophthalmologie Bd. ix. 1, for the Medical and Surgical Reporter,

By A. Metz, M. D.,

Of Masillon, Ohio.

(Continued from page 373.)

III.

Strabismus Divergens.

"Divergent strabismus, as a rule, is connected with myopia. In the beginning of my statistical investigations, the connection between *strabismus convergens* and hypermetropia was not more doubtful; yet I was far from suspecting that *strabismus divergens* stands equally in as close relation with myopia. Systematic investigations brought this first to light.

"The kind of connection, however, is not alike in both cases. When hypermetropia brings about *strabismus convergens* it does it through the power of the act of accommodative effort demanded by the anomalies of refraction. When *strabismus divergens* is found in connection with myopia, then are the anomalies of refraction as such, it is true, not without their importance in the matter, it is still the anatomical basis that presents itself as the cause; I mean the expansion and altered form of the eyeball;—when exceptionally the myopia is dependent on the diminished curvature of the corneal semi-diameter *(vermindertem Krummungs halbmesser der cornea)*, then there is no strabismus to be looked for. Arlt has shown by anatomical investigations that myopia, as a rule, originates from the expansion of the membranes of the posterior segment of the eyeball, and lengthening of the optic axis. This important fact is now universally acknowledged as true. In myopia, all the diameters of the bulb are increased, and generally most in the direction of the optic axis. The consequence is that the bulb of the eye approaches in form an ellipsis, the longest diameter of which is the optic axis. The larger diameters in general impede the freedom of motion, and especially the ellipsoidal form, which by turning around the small axis in an equally formed cavity, and by the change of form thereby demanded, offers great resistance. Moreover the centre of motion* does not only increase its distance from the anterior surface of the eye, but also from the posterior. Its position otherwise is not unfavorable. In the investigations made conjointly by myself and Dr. Doyer, it was ascertained that the centre of motion is behind the middle of the optic axis, and in this manner, that the part of the optic axis anterior to the centre of motion holds the relation to the part posterior to this part of 15 to 11. Nearly the same relation was found in the longer axes of myopists; the optic centre lies here also further from the posterior surface of the eyeball. The excursions are also, for equal grades of rotation, larger, and the turning is necessarily limited. This limitation would be still greater were it not for the disproportionate expansion of the outer back part of the segment, the optic nerve entrance pushed inward and considerably less removed from the centre of motion."

Aside from all other considerations, the lengthened eyeball sufficiently accounts for the existing restraint, which affects the motion inward as well as outward. This is so common in myopists that in seventeen eyes nine could not turn sufficiently to permit Donders to determine, without change, by his method, the centre of motion *(Drehpunct)* of the eye, which only requires an excursion inward and outward of 28°. The limited motion has no other bad result, only that binocular vision demands the turning of the head, which is always necessary when using glasses. But the insufficiency of motion inward has other more important results, which will be successively considered, so that at last it will be seen that absolute divergent squinting follows.

By insufficiency of motion inward is understood when the optic lines cannot be brought to cross at

* *Drehpunct* in German. Pile defines it, "The bulb must be considered as a ball revolving around a fixed, motionless point (*Drehpunct*) situated nearly in the middle of the organ, the motions of which are not changes of place, but merely a rotation around this point."—*Translator.*

a distance of 2″ 5, by which they cut each other at an angle of about 51°. In high grades of myopia this insufficiency prevails almost without exception. A two-fold cause is given. In the first place, the motion, as we have seen, is lessened by the expansion and alteration of form of the eye, and the restriction is so far positive. In the second place, in order to have the optic lines cross each other at the distance of 2″ 5, from the small size of the angle *a*, the corneal axes must be brought to a stronger convergence than in emmetropic eyes. It will thus be seen that the motion inward, if not absolutely restricted, must be so at least relatively.

The insufficiency here spoken of leads in some cases to fatigue in seeing, when the occupation demands for a long time a certain degree of convergence (*asthenopia muscularis*).

Donders observed cases in which seeing took place with both eyes at first, but after fatiguing the eyes the one would turn aside, and the labor thus would cause less distress; in other cases, however, the deviation was obvious and followed by fatigue and uneasiness. The latter cases occur when the myopia is relatively slight, and when beside the resistance of the eye there is a certain weakness of the muscles, not merely insufficient motion, but true inefficiency of the *musculi recti interni*. By this turning aside with continued exertion, *relative strabismus divergens* is brought about. At greater distance the optic lines are well directed; by close work only one eye is used.

The relative divergent squinting is here regarded as the result, and in a certain measure as a further development of insufficient motion inward. Up to a certain point this is correct. In attempting to determine relative squinting then, we perceive that it is inseparable from high grades of myopia, and that if there was no restriction of motion that it would nevertheless exist. Relative divergent squinting is present whenever the acuteness of vision demands the nearness of the object so as to exclude binocular vision. It is also present in unrestricted convergence, as soon as the furthest point of distinct vision lies nearer to the eye than the point reached by the strongest convergence. In this sense, for example, by m.$>2\frac{1}{5}$ there is necessarily relative divergent squinting; one eye certainly does (cases of *strabismus convergens* excepted) when there is good sight without glasses, and is always turning outward.

Relative divergent squinting then may exist on the one hand with considerable inefficiency of the *musculi recti interni* altogether without myopia, and on the other side in high grades of myopia without any muscular deficiency. It presents itself only in its most decided forms, when myopia and muscular deficiency are combined. Myopia is our point of departure. When myopia is wanting then the inefficiency leads to *asthenopia muscularis*, and is seldom developed into *strabismus divergens*. When myopia is present, then a number of causes combine to produce *strabismus divergens* at least relatively, and thus prevent the *asthenopia muscularis*. Myopia demands more convergence of the optic lines from the fact that objects are seen nearer the eye; and in consequence of the myopia, the convergence is more difficult for two reasons, first, on account of the restricted motion, and second, on account of the altered direction of the optic lines (the smaller angle *a*). It is thus rendered clear that relative divergent squinting proceeds from myopia. In addition, the necessity of binocular vision and the horror of double images are here no important counterpoise. It is mostly a small object that the myopist desires to see distinctly; he approaches it close to the eye he wishes to use, the other eye being directed on distant objects, which, in consequence of the myopia, it presents diffuse and but slightly disturbing images. If now in seeing with the turning aside of one eye, so there is otherwise a less desire of convergence, as thereby at the same time the distance from the furthest point of vision becomes smaller, and the object is still brought nearer to the eye. It is in difficult convergence that associated exertion of accommodation becomes especially irksome.

The conflict between binocular vision and relative divergent strabismus is often witnessed in progressive myopia. The increasing fatigue soon yields to squinting. For example, reading begins binocularly, but after a time the one eye turns involuntarily and unconsciously aside, so that complaint is made that one side of the page is pushed over on the other. Many transitional symptoms may be observed. If the object be brought more and more near, then the convergence is increased almost to its maximum. If the object be kept near, then the one eye turns aside the more rapidly, the nearer it approaches the maximum of convergence. It immediately turns aside when the object is brought inside of the convergence maximum. The same happens when by strong convergence the one eye is covered with the hand. If the hand is removed the deviation will nevertheless continue. Even when the object is brought nearer to the eye, whilst the other eye is covered with the hand, it is seldom that it is brought to the necessary convergence. The exertion at greater distance to retain commenced binocular vision, is the condition under which the convergence takes place; by complete, stable, relative divergent squinting it does not occur. As transition, it is observed that it stays away on exhaustion and recurs after recruiting by rest.

"On the transitional line between the changing and permanent relative divergent squinting, there

is another important practical condition to which I heretofore referred. It is this: there is yet an inclination to convergence, as is seen by bringing an object nearer; but even before the distant point of vision is reached, or at least soon after, the one eye already turns to one side. If concave glasses are now used so as to bring the binocular far point to 8″, 10″ or 12″, then seeing again takes place with both eyes. Under such circumstances the complaint of fatigue is heard, and investigation teaches that it is not the exertion of accommodation that causes it, but the demanded convergence even when it is relatively trifling. As a consequence, *asthenopia muscularis* is concerned, when, in order to render possible binocular vision, it is necessary to use concave with prismatic glasses. In these cases it is clear that the cause of relative divergent squinting only rests in the restricted motion inward, whilst the struggle to bring about binocular vision may continue undisturbed. It is only in absolute divergent squinting, as we shall see, that it frequently is relieved."

It has thus been shown that in progressive myopia the struggle for binocular vision is ordinarily vain. There are exceptions to this. GRAEFE says "A powerful united action of the *recti interni* belongs to relative normal short-sightedness," (Archiv. f. Oph: iii. S. 309.) He considers it a pathological condition when the increase of force in the internal muscles is not harmoniously developed with the increase in the refracting condition (of myopia). Sometimes, even in high grades of myopia, the optic lines may be held properly directed on near objects, without painful tension. This may be from favorable alteration of form of the eye, or from original or acquired preponderance of power of the internal muscles. This is mostly at the cost of motion outward, and restriction of motion outward is never absent, and it may reach such a high grade that the optic lines when seeing distant objects cannot be brought to parallelism, and relative convergent squinting then exists. It happens also that the convergence may be insufficient, when we have the singular combination of relative divergent squinting by seeing objects near, with relative convergent squinting by seeing at a distance, whilst there is at medium distance a certain space left for binocular vision. It reminds us of the combination of myopia with presbyopia. But all this belongs to the exceptions. The rule is that the facility of convergence does not keep step with the developement of the myopia, and that very soon relative divergent squinting is observed. Investigations prove that myopia soon restricts motion inward, whereas outward motion does not suffer in this way; that the optic lines can be brought to a greater divergence by the use of a prism, than in persons not myopic.

Absolute divergent strabismus is characterized by divergence of the optic lines at a distance. In seeing near objects the divergence sometimes remains unchanged. Sometimes it diminishes and a convergence takes place, which is however insufficient. Binocular vision at any rate is excluded. DONDERS noticed a few times that seeing at a great distance divergence took place, which, on lessening the distance a few feet would give place to convergence, which is only momentary, however; the fact is worth observing. The explanation may be that binocular vision has more significance for the perception of near than for far objects. At first, divergent strabismus is usually slight and increases but slowly. At times it remains at a trifling grade for a lifetime. It is suspected that the highest grades of strabismus have not seldom another origin than simple myopia.

It is only to the absolute that the name of squinting is usually given. In this sense it is less frequent than *strabismus convergens*. If in addition the other causes of squinting are deducted, as paralysis, or inflammation of the muscles, cramp, or congenital anomalies, then myopia does not hold so important a relation to divergent squinting as hypermetropia does to convergent squinting. Myopia is found in two-thirds of the cases of absolute divergent strabismus. If we add the relative divergent strabismus, then it is more frequent than the convergent, and myopia is found to be present in ninety per cent. of the cases of the former. Convergent strabismus is usually seen early in life, in childhood; divergent strabismus is seen in later years. The fact rests on the cause of the origin; myopia is progressive.

As a rule, though absolute divergent strabismus is developed from the relative, it is yet far from common for the absolute to follow the relative. The converse is the exception. As the majority of hypermetropists do not have convergent squinting, so we find a majority of myopists with relative divergent squinting, out of which the absolute is not developed. The question also follows, What collateral conditions are essential to develope the true absolute divergent strabismus?

First then, why, as a general rule, does the relative deviation have a tendency to the absolute? Relative divergent squinting causes, at least in seeing near objects, different images on both *maculæ lutæ*. The necessity of unity of impressions, the striving for single, binocular vision must as a general thing be weakened. A certain beginning convergent deviation immediately reaches a high grade, as the patient yields singly to the contractions of the muscles—perhaps also unconsciously to separate further the double images, and perhaps also to avoid the fatiguing convergence associated with accommodation, and thereby remove further

from the eye the far point of vision. For example, in blindness of one eye, the inner straight muscles are no longer made tense to accomplish binocular vision at close distance, so they will soon not act sufficiently for want of energy, and *strabismus divergens* is the ordinary result. Relative divergent squinting also soon leads to want of proper action, also the result of diminished energy. Here then we have two important facts meet: diminished aversion to double images, and diminished power of the inner muscles; and it need not seem strange that soon in seeing at a distance their action will no longer be adequate. Sooner yet in myopists this must occur, in whom the angle *a* is peculiarly small, and consequently seeing at a distance demands a less divergence of the corneal axes than in emmetropists. When the action of the inner muscles is once weakened, then must the exertion necessary to overcome divergence easily bring nearer to the eye the far point of vision, and render the retinal images of distant objects yet more diffuse, and instinctively the exertion ceases. Here then we have without doubt, the formation of absolute divergent strabismus illustrated. Now then we will reverse the question and ask, Why is it that not every relative divergent squint leads into the absolute?

Absolute divergent squinting in high grades of myopia is also quite common, much more so than at first believed. Trifling grades pass unnoticed, when even the optic lines diverge, the corneal axes show no special divergence, less than in hypermetropists not squinting; it is only by covering the well directed eye with the hand that it becomes manifest that the optic lines of the other eye are directed too much outward. But further, in reply to the question asked.

The cause consists in part in the forced retention of binocular vision. Even when in consequence of relative divergent squinting, the struggle for identical impressions on both *maculæ lutæ* and other corresponding points is weakened, it is still not extinct. This struggle alone sometimes opposes the deviation. In many cases the eye behind the covering hand turns itself out, and on the removal of the hand it resumes its proper position. And when the deviation remains absent, it is only necessary to convince us of this struggle, to place a weak prismatic glass with the refracting surface toward the nose, and immediately the prism corrects the convergence. Only in the highest grades of myopia, in which a strongly marked object does not make an identical impression, is it that this experiment fails to call forth the convergence. From this we infer that acuteness of vision is not an absolute condition in order to see and retain singly.

We further seek for the cause of the absence of absolute strabismus in the restricted mobility of the eyes, not only inward, but sometimes the ellipsoidal eyeball of myopists interferes with the turning outward also. This hindrance may extend so far, as that, as before remarked, in far seeing we may have relative convergent squinting, and in near seeing relative divergent squinting. When even it does reach this grade, so it still hinders a free turning outward, even should binocular vision demand it.

Here we are just as we were in convergent strabismus, different impelling and opposing forces arrayed against each other, and it is indeed difficult to say in what conditions the overbalance will fall on this or on that side.

We must consider, first, circumstances that demand motion outward; second, such as take away the value of binocular vision. To the first we attribute original overbalance of the outer straight muscles of the eyes, greater than the ordinary displacement of the optic lines resulting from myopia (unusually small or negative value of the angle *a*), and further, favorable form of the eyeball for outward motion, and prominence of the same. As to the second, we can enumerate diminished acuteness of vision of one eye, and above all difference in the refraction of the two eyes. This latter is an influential fact. When the difference of refraction is great, the one eye strong, the other hardly myopic or even emmetropic, then it is perhaps the rule that in seeing at a distance, the myopic eye is turned outward. These cases present a peculiar kind of *strabismus divergens* which unconditionally deserves to be thoroughly investigated and described by itself. Sometimes, especially in the beginning, the squinting is inconstant, and shows itself only after fatigue or in certain mental conditions; in other cases, even when strongly developed, it can be overcome by the will in near seeing for a short time, yet not without fatigue and without advantage to sight. It happens also sometimes that one eye is used for far seeing and the other for near seeing. Mostly each judges correctly, as it sees independently, notwithstanding that the object is seen with the one eye larger and with the other eye smaller. We can readily discover that in these cases binocular vision is not worth much; and that in seeing ordinary objects at a great distance, the double images are hardly observed, and that the strongly myopic eye readily turns aside; and that the restricted motion here only concerns the one eye, and a relative turning outward is rendered more easy; and finally, that as soon as there is demanded an exertion of the *musculi recti interni* to prevent divergence of the optic lines, that the same therefore will have to fail as the slightly myopic or emmetropic eye, which at a distance sees rather

distinctly, in consequence of the associated exertion of the accommodation, immediately perceives less acutely.

In closing his article, Professor DONDERS refers briefly to what authors had previously said on this subject, which want of space excludes. I had intended only to prepare a brief abstract of this interesting article, but the style of the author hardly admits it. He says very little not essential to the full comprehension of the subject he discusses. After reviewing what BUFFON, MUELLER, BOHM and RUETE have written on this subject, he thus concludes:

"On the whole, the satisfaction is small in consulting the rich literature on strabismus with reference to its causes. Particularly was *strabismus divergens* treated in a very step-mother-like manner for a long time. A distinction according to its forms is not to be found, and where the causes of strabismus are discussed in general, all seems to refer to *strabismus convergens*. It remains only for me to refer to the writings of VON GRAEFE with reference to inefficiency of the inner straight muscles, in which we find numerous modifications of the partial transition to *strabismus divergens*, and which VON GRAEFE has also noticed. He talks thus in his last treatise (Archiv. f. Oph: Bd. viij. Abth. 2): "According to the distance of the objects seen, the inefficiency may be defined as variable, dynamic divergent squinting, which at times is overcome by the struggle for single vision." When we consider, as GRAEFE has already declared, that in myopia this impulse must exist, then it seems as if, under certain conditions, the developement of absolute divergent squinting from myopia was already visible before us.

"So it is! The contrast is indeed striking:

Hypermetropia causes accommodative asthenopia, which in an active manner is overcome by convergent squinting.

Myopia leads to muscular asthenopia, which in a passive manner passes into divergent squinting."

Hospital Reports.

PHILADELPHIA HOSPITAL,
Nov., 1863.

SURGICAL CLINIC OF DR. D. HAYES AGNEW.

Reported by *Dr. Josiah Reeve, Jr.*

Bromine in the treatment of Sloughing Ulcers.

GENTLEMEN: I bring this man before you to illustrate the beneficial effects of Bromine in the treatment of sloughing sores. Personally, I have had little experience with it, but the success with which it has been used in certain military hospitals has been such as to induce every thinking man to give it a fair trial. This man, as you see, has a great cavity in the perineum: it is literally all sloughed out, exposing the spongy portion of the penis and the triangular ligament. This began four weeks ago in the form of a small sinus about three inches in length, which was laid open before you, as you well remember. From that time until within the last few days it has been rapidly increasing in size, in defiance of nitric acid, nitrate of silver, sulphate of copper, and other similar applications. Five days ago a solution of equal parts of bromine and water, and sufficient bromide of potassium to make the solution complete, was applied, the parts being thoroughly saturated every morning for three days, and warm water dressings used in the interval. After the third application the slough began to separate, and now you see granulations of a healthy character, are springing up. The constitutional treatment consisted in the administration of quinia and iron, with the best diet of the house, also four ounces of brandy daily. The local treatment at present is gently stimulating—the sore being packed with lint saturated with a weak solution of nitric acid, namely. three drops of nitric acid to an ounce of water. The man's general health is much improved, and he is in a fair way to recover.

Fractured Ribs.

This man states that one week ago he received a blow upon his right side from a passing car, and that since that time he has been suffering very much from pain in the side, of a sharp, gritting character, and from a short, dry cough, as I proceed to examine the side, by passing my fingers over the ribs, I find no deformity, but by pressing with my thumbs—one upon the sternal, and the other upon the vertebral extremity of the eighth and ninth ribs, I discover marked crepitus, thus proving the existence of a fracture. The floating ribs are seldom fractured because of their mobility, being attached at only one extremity, and also enveloped in muscles. The cough in this case arises from the broken extremities of the ribs, irritating the pleura or the intercostal nerves. The treatment in fracture of the ribs consists in the application of a tight roller round the body—applied from below upward—or in the application of adhesive straps, which method I prefer. The straps should be two inches wide, and long enough to reach from the spinal column to the sternum, and applied in a line parallel with the ribs and not transversely, for, we should in that case have the force used in the wrong direction. This dressing need only be renewed four or five times, as it requires but four or five weeks for perfect union to take place.

Hydrocele.

This man comes before you with a tumor of the scrotum, of the nature of which I have not fully satisfied myself. The occupation of the man, which is that of an aeronaut, would naturally expose him to accidents involving these parts, having, as he states, several times been obliged to ride for fifteen or twenty miles astride of a rope. Now the question is, what is this tumor? It may be hernia, swelled testicle, hematocele, or hydrocele. I first notice the general shape and appearance of the tumor, which is that of hydrocele, being pear shaped, but this is a point of minor importance, being present in other diseases. If it were hernia I should expect, when I grasp it and the patient coughs to feel an impulse given to the tumor, but I feel none; this added to the history of the case, which is that the swelling began in the lower part of the scrotum, leads me to believe that it is not hernia. By examining the tumor more closely I find the testicle at the bottom

of it, which is the point assumed by it in hernia. In hydrocele it is generally found more in the posterior part of the scrotum, and some distance from the bottom, but you will remember that in the last case of hydrocele I had before you it was at the bottom, so that its position is no certain guide in the diagnosis. By grasping the tumor and tapping it with my finger I discover marked fluctuation, but this is also deceptive, for it might depend upon hæmatocele, or the fluid in the sack of a hernia. The test by transmitted light is considered a very important one, but it also has failed in this case, as it does in all cases where the tunica vaginalis testis is thickened, or the fluid opake. In this case the tumor appears perfectly opake. There is but one infallible method of diagnosis, and that is by the exploring needle, which, when introduced, will give us a few drops of fluid, if such there be. You see fluid escaping now along the grove of the needle; if there should have been none the introduction of the needle would have inflicted no injury upon the patient. The treatment of hydrocele is both palliative and curative; in this case I shall only make use of the former on account of the patient desiring to leave the house immediately. The operation consists in simply introducing a trocar armed with a canula, and withdrawing the fluid, which is generally of a pale, straw color. This is done, as you see, by grasping the tumor with the left hand, taking care that the testicle is out of your way, then introduce the trocar perpendicularly through the skin. When it reaches the tunica vaginalis, it should be directed upward, thus making a valvular opening, and the fluid escapes through the canula. I shall say nothing at present about the radical cure of the disease, for I shall have cases before you this winter which will demand such treatment. In cases like the present one, where the tunica vaginalis is so thickened and the testicle exquisitely tender it would be improper to use stimulating injections in order to cure the disease permanently.

Hypertrophic tumor of the Labium.

L. A., aged 28 years, was brought before the class, with her consent; on account of a hypertrophic tumor of the left labium majorum. The patient has had the swelling for more than a year, and though, at first being small, it did not interfere with her comfort, of late it has become a source of great annoyance, from its great size, and from the pain which it causes her when performing her active duties. About two years ago a similar tumor was removed from the opposite side, affording great relief—it has not recurred. The labium was several times its normal bulk, dense, and elastic. No assignable cause could be traced from the history of the case.—Excision of the mass was determined upon, and was performed by making elliptical incisions from above downward, thus excising a portion of the integument. The fibrinous mass was dissected out, the larger vessels ligated, and the parts approximated by several interrupted sutures of lead wire. Cold water dressing was applied and retained by the spica of the groin. This class of tumors of the labia is generally of a fibrous character; not malignant or recurrent. Excision is the only radical cure.

Jefferson Medical College,
October, 1863.

Surgical Clinic of Prof. S. D. Gross, M. D.

Reported by *Dr. J. Gordon Maxwell.*

Internal Hemorrhoids.

James C. C., 61 years of age, wood-sawyer by occupation, Altona, Pennsylvania. The disease had existed for upward of 30 years, causing considerable pain and a feeling of stuffing in the ano-rectal region with occasional hemorrhage of an alarming character.

An examination being made, six hemorrhodial tumors of unusually large size were discovered, situated a few lines above the verge of the anus and grouped closely together, of a soft spongy, erectile and elastic character, diminishing under pressure but regaining their former volume the moment the tension was removed.

Dr. Gross performed the operation of strangulation; each tumor being drawn down by a tenaculum and tied with a stout well waxed thread of saddler's silk, secured with a double knot, and the ends cut off close to the surface. The operation being over, the patient was put to bed in the College Hospital, and a full anodyne given to relieve pain and paralyze the bowels. No untoward symptom arose, the bowels remaining locked up until after the ligatures came away, as they did on the sixth day after the operation, and the patient is so well that he will be able to return to his home in a day or two fully relieved of his annoying disease.

Caries of the Foot.

Aaron G., 46 years of age. The patient, a German, of a strumous diathesis, noticed a swelling on the outer side of his right foot about 4 years ago, at the same time his health, which had previously been good began to fail, his appetite to decrease, and his sleep to be troubled. In this condition he remained for upwards of a year, when an opening occurred spontaneously in the affected surface, discharging a thin, ichorous, fetid fluid, so irritating as to erode the parts with which it came in contact.

When brought under notice the disease had become chronic in character and therefore most favorable for an operation. Chloroform having been administered a free incision was made and the diseased structure removed by means of the gouge and bone drill. The canal was then well washed out with the syringe in order to effect thorough clearance; the bleeding from the osseous tissue was considerable, but soon ceased under the application of cold water dressing. A tent was introduced for the purpose of promoting granulation from the bottom. A full anodyne was given to relieve pain and promote sleep. Since then everything has gone on in the most favorable manner and granulations of a healthy character are springing up.

Pott's Disease of the Spine.

Caroline W., 3 years of age. In this case the disease was of short standing, with but slight curvature, and Dr. Gross remarked that if the injunctions of the physician and not the cries of the child were obeyed there was every probability of a good cure. The actual cautery was then applied a little above the seat of the curvature, making an eschar about the size of a twenty-five cent piece, after which a towel soaked in cold water was employed for six hours when the permanent dressing, a flax-seed poultice, was substituted.

In addition to the issue, Dr. Gross ordered perfect recumbency upon a trundle-bed until the disease shall be ended, the child not being permitted to get up for any purpose whatever. The period required for a cure will vary from three to twelve months. Her diet is to be plain and simple but nourishing; a drachm of cod liver oil is to be taken thrice a day, and attention paid to the bowels and secretions.

Effect of Sugar and Tobacco on the Teeth.

The effect of sugar and tobacco on the teeth was discussed at a congress of German Surgeon-dentists recently held at Frankfort. The congress decided in both instances, that the articles, when taken in a pure state, and not in immoderate quantities, are not injurious.

MEDICAL AND SURGICAL REPORTER.

PHILADELPHIA, NOVEMBER 21, 1863.

PREMIUMS FOR NEW SUBSCRIBERS.

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For any effort made by our subscribers to extend the circulation of the REPORTER they will be well repaid in the improvements it will give us the means of making in the work. The REPORTER is already the most widely circulated medical journal by far in the United States, but we are anxious as speedily as possible to double its circulation that we may be enabled to add correspondingly to its interest and usefulness.

We print on another page a list of the more important medical books published, from which selections may be made.

CORONERS.

There are some important offices that are often very improperly filled in this country. One of these is that of Coroner. No one we presume will question the propriety of always placing a medical man in that office. Its duties require, for their proper and economical performance, a knowledge of medicine, and especially of anatomy, on the part of the incumbent of the office. Post mortem examinations are frequently necessary, and questions often arise involving a knowledge of the properties, doses and actions of medicines. Medico-legal investigations have also frequently to be entered into. In fact there is no part of the duty of a Coroner that does not necessarily involve medical questions. A Coroner's jury is *de facto* a medical court, and should at least be presided over by a medical man. And he should be competent in the first place to summon a jury with sufficient intelligence to comprehend the case in hand; secondly, to enlighten its members on questions that may be developed in the course of the investigation; and lastly, with a judgment capable of distinguishing cases requiring a thorough medico-legal investigation, and of selecting the experts needed in such an emergency.

Unfortunately, with us, the office of Coroner is an elective one, and the principal qualification of the candidate has usually had a political, rather than a professional signification. He has been selected with a sole view to his ability to "run" well, and to the influence his name will have on the party ticket. Good medical men are seldom politicians, so that they are usually left out of the calculation entirely for the office of Coroner when the ticket is made up. The consequence is, that responsible and highly important office is more likely to be filled by a tavern keeper, a cobbler or a butcher, than by a medical man. A further consequence is a mockery of justice on every occasion where an inquest is requisite.

As a measure of economy, it would be policy to elect intelligent medical men to the office of Coroner. Where this officer is not a medical man he is often compelled, at an additional expense to the community, to call in medical advice in many very simple cases, and from his previous associations he is apt to select persons of questionable ability as his advisers.

It is very desirable that this important office should be withdrawn from the arena of politics, and that intelligent, high-toned medical gentlemen should always be elected, or rather appointed to it. At a recent election in this city, a medical man of respectable standing was elected Coroner, and we trust that the case will be a precedent, and that while the office is an elective one the political parties will see the propriety of selecting competent, respectable medical men as candidates to fill it.

"BE COURTEOUS."

To no class of the community is the apostolic injunction at the head of this article more applicable than to medical men. In the society in which he moves—and he moves in all classes of society—he should be a pattern of politeness, courtesy, gentility and good breeding. True gentility is consistent, the same under all circum-

stances, influencing its possessor in his bearing toward all classes of society. It will restrain him from falling into many of the vices and bad habits which beset so many to their manifest disadvantage. The truly courteous physician will, for instance, avoid falling into such doubtful habits as the use of tobacco, to say nothing of intoxicating drinks; for a breath redolent of such things is totally unfit to carry into the presence of any sick person, especially if the person should be a lady. And this is the smallest objection that can be named against the use of the articles in question. We are perfectly aware that in these remarks we tread on many a reader's toes, and we do not care to tread lightly, either, for the evils adverted to are crying ones, and unbecoming and disgraceful to our profession. A medical man's brain should be clear, and his breath sweet, when he approaches the bedside, or comes into the presence of a patient.

This is a trite subject, one that is descanted upon in our text books and in the lecture room, but it is of sufficient importance to warrant repetition. We will conclude this branch of it with some apt quotations from the pen of the versatile and gifted Dr. O. W. Holmes.

"Be gentle, then; though Art's unsparing rules
Give you the handling of her sharpest tools,
Use them not rashly—sickness is enough,—
Be always "ready," but be never "rough."
* * * * * * * *
Kindness—untutored by our grave M. D.'s,
But Nature's graduate, whom she schools to please,
Wins back more sufferers with her voice and smile,
Than all the trumpery in the druggist's pile.
Once more, be quiet;—coming up the stair,
Don't be a plantigrade, a human bear,
But stealing softly, on the silent toe,
Reach the sick chamber ere you're heard below.
Whatever changes there may greet your eyes,
Let not your looks proclaim the least surprise;
'Tis not your business by your face to show,
All that your patient does not want to know;
Nay, use your optics with considerate care,
And don't abuse your privilege to stare;
But if your eyes may probe him over much,
Beware still further how you rudely touch;
Don't clutch his corpus in your icy fist,
But warm your fingers ere you take the wrist.
If the poor victim needs must be percussed,
Don't make an anvil of his aching bust;—
(Doctors exist within a hundred miles,
Who thump a thorax as they'd hammer piles!)
If you must listen to his doubtful chest,
Catch the essentials and ignore the rest.
Spare him; the sufferer wants of you and art,
A track to steer by, not a finished chart;
So of your questions,—don't in mercy try
To pump your patient absolutely dry,
He's not a mollusk squirming in a dish,
You're not Agassiz, and he's not a fish.
And last, not least, in each perplexing case,
Learn the sweet magic of a *cheerful face;*
Not always smiling, but at least serene,
When grief and anguish cloud the anxious scene,
Each look, each movement, every word and tone
Should tell your patient you are all his own;
Not the mere artist, purchased to attend,
But the warm, ready, self-forgetting friend,
Whose genial visit in itself combines,
The best of cordials, tonics, anodynes."

There is a class of medical men to whose special notice we desire to present the injunction which we have made the foundation of these remarks. We refer to medical officers of the army and navy. Our remarks are not applicable to all of them by any means, but there are too many of them who need a word of caution on this subject. Some doctors, as soon as they mount a uniform, become so self-important and dignified as to be unapproachable. They treat officers of inferior grades, privates and civilians with disdain. Such men show their breeding, or rather want of it, and disgrace themselves, their profession, and the service in which they should be an ornament. We have had instances of discourteous behavior related to us on the part of medical officers that have made us blush for our profession. It is very sad to see an official announcement of the dismissal of medical officers "for conduct unbecoming a gentleman," but if all who are guilty of such conduct should get their deserts the humiliating record would be long drawn out, we fear.

Notes and Comments.

The Surgeon-General.

Surgeon-General Hammond, on his arrival at Washington, after inspecting the hospitals in the Departments of the South and the Gulf, was immediately ordered on a like service to the hospitals in the Western Department. We do not understand, however, that this necessarily indicates any particular mismanagement of the hospitals in that Department. Such an inference was very unjustly drawn by one or two of our cotemporaries when the Surgeon-General was ordered to inspect the hospitals in the other Departments.

Nitrous Oxyde as an Anæsthetic.

It will be remembered by our readers that the first practical application of an anæsthetic for surgical purposes was by the late Dr. Wells, of

Hartford, and that he began his experiments with nitrous oxyde vapor, and subsequently resorted to sulphuric ether.

Nitrous oxyde vapor is now being very extensively used for anæsthetic purposes, particularly by dentists. It is preferred on account of its supposed safety, there being, we believe, no case recorded of loss of life from its use.

Mitchell's General Atlas.

We have seen a late edition of this Atlas which, in addition to the United States Post Offices, has a list of those of the neighboring British Province of Canada. We would again commend the work to the notice of our readers. It is almost indispensable in every family in such eventful times as these.

Correspondence.

FOREIGN.

LETTER FROM Dr. W. N. COTE.

PARIS, *Oct.* 23d, 1863.

Arsenical Coloring.

Notwithstanding the many warnings given to manufacturers, as well as to the public, arsenical colors are still extensively used. Dr. GUY, in his recent report on the subject, states that arsenical green is commonly used for coloring prints, paper-hangings, or ornamental papers, tarlatans for ball-dresses, and artificial flowers, and less generally for tinting confectionery—and its application to all those purposes is attended with more or less danger to human life, and with almost certain injury to the health of the persons who manufacture or make use of the articles colored with it. The name under which it is best known is "emerald green," being the same as Scheele's or Schweinfurth green. Its chemical composition is arsenious acid, six parts; oxide of copper, two; and acetic acid, one; so that it is needless to say that it is a very active poison. The manufacture, when carried on in the open air, does not occasion much inconvenience to those employed in it. The men who make the powder suffer from boils and pimples, or from a little itching in the nostrils and around the bends of the arms; and those who pack it are liable to itching and sneezing, but that is all. When the work is done under cover, more serious effects are produced. The workmen are then affected by blotches, rashes, and much itching. Those who drink suffer most—but if the work is discontinued, and more especially if cooling medicines are administered, the symptoms soon disappear. The injuries occasioned by the emerald green are not confined to, nor do they indeed chiefly or in any great degree arise from, its poisonous character when swallowed. Mischief does, however, occasionally spring from that cause. Confectioners and pastry-cooks were, until lately, in the habit of using the emerald green as a pigment; and instances are recorded of dangerous or fatal consequences occurring to children from eating fragments of ornamental baskets, cake ornaments, sweetmeats, or apple tarts, colored with the poison; and to adults, from its ignorant use for the tinting of blanc-mange. But it is from the diffusion of the powder in the atmosphere, and its absorption into the system with the breath or through the skin, that the most serious consequences flow; and as far as those who are not engaged in manufactures in which the color is used are concerned, the most general risk arises from its employment in the staining of paper-hangings. In such cases the quantity of "emerald" employed is often as much as from twenty-eight to seventy grains to the square foot. It is generally very loosely attached to the paper, and is easily liberated, when, especially if its effects are increased by damp, its presence in the air frequently produces very serious and well-marked indispositions. Paper-hangings colored with the emerald green are, it is true, often used without inconvenience; but the cases in which injury has resulted to persons occupying rooms hung with them are too numerous and too well authenticated to admit of doubt as to their cause. In the manufacture of artificial flowers, fruits and leaves, the deleterious effects of emerald green are most fully experienced. In other occupations it produces only inconvenience and suffering—at the most, illness of some duration and severity—but in this it has, in one instance at least, probably in more than one, led to fatal consequences. The sufferers in this case are chiefly women. In concluding his report, Dr. GUY suggests that for the protection of the public, the sale of this poisonous green to toy-makers and confectioners should be forbidden, and that all tinted papers and paper-hangings which are colored with it should be marked "arsenical paper." As to the employment of emerald green in manufactories, he is of opinion that, as far as men and women are concerned, no case is made out which would justify any special legislation of a highly restrictive character. The case of young children is somewhat different, and for their protection we think that employers might be prohibited, under a penalty, from allowing any person under eighteen years of age to work with the emerald green.

Power of the Imagination.

I take from the *Nord* the subjoined narrative, which shows the influence imagination can exercise on the body. That journal vouches for its authenticity. "A gentleman, of great energy of character, while staying at a hotel at Turcoing, was seized with excruciating toothache, accompanied with swelling of the gums. He was recommended to apply a leech; and the keeper of the hotel undertook the operation, using a piece of paper folded up so as to form a kind of case. At the end of a few minutes, as the sufferer did not feel the leech, an examination took place; but the leech was not in the paper, and it had disappeared. It was immediately concluded,

to the great horror of the sufferer, that he had swallowed the mordant worm. No sooner was this dreadful conclusion arrived at, than the affrighted man felt terrible bites in his stomach; and, although he swallowed a glass of oil of sweet almonds, renewed bites showed that the leech was still alive. A Doctor was called in, and an ounce of castor oil administered immediately, but repeated, agonizing pains proved that the leech was in another part of the stomach. A dreadful fear now took possession of the unfortunate man, who anticipated that his intestines would be soon perforated, and that death was certain. A second Doctor called in, prescribed two more ounces of castor oil, which the patient swallowed most stoically, but the bites and pains were renewed. The hotel-keeper happened then to change his coat, and in his sleeve he found the leech, which had made its escape at the end of the paper held to the gum of the sufferer. The unfortunate man was thus assured that his life was no longer in danger, but he was a prey to the most uncomfortable sensations from the three ounces of castor oil which he had swallowed."

Chloride of Iron and Chloride of Sodium as a Hæmostatic.

Dr. Piazza, of Bologna, has introduced a new preparation containing chloride of iron, which he has found very efficacious as an hæmostatic agent. You are aware that a solution of chloride of iron has already been used successfully for stopping the flow of blood from wounds, but in a concentrated state it often causes much pain and irritation. It appears that when chloride of sodium is added to it, the proportion of chloride of iron may be considerably diminished. The solution Dr. Piazza recommends is composed of perchloride of iron having a specific gravity of 1.075 to 1.11, mixed with an equal volume of a concentrated solution of chloride of sodium. Great success seems to have attended the use of this solution in Italy and Belgium. The chloride of iron should have no free acid in it.

Whooping-Cough.

Dr. Domerc publishes two cases of whooping cough, in which the patients were adult females. After trying emetics, sedatives, anti-spasmodics, and sulphate of quinine, with but temporary success, he prescribed cigarettes of belladonna, which caused relief, but led to no cure. At length he had recourse to the following preparation: Take leaves of belladonna cleansed of their stalks, 90 grammes; add tops of melitot, a pectoral herb, 10 grammes; mix in a porcelain basin, and pour on it 5 grammes of laurel-water, stirring all the time, until the whole is perfectly moistened. Then add the following solution:

℞.	Tincture of iodine,	10 grammes.	
	Iodide of Potassium,	2	do.
	Nitrate of potash,	8	do.
	Laurel-water,	30	do. M.

The whole is left to stand until the superfluous moisture is evaporated, when 10 grammes of the tincture of balsam of tolu are added in drops all over the mixture. This done, the leaves are cut into shreads like tobacco, and so kept for use. The patient smokes it under the form of cigarettes, or else in a small pipe. It generally cures the affection in the course of a week; and is found also serviceable in phthisis, catarrh, and asthma. Sometimes Dr. Domerc prescribes iodized inhalations to be taken alternately with the above, in the following manner: Put a little amiantus or earth-flax, or else cotton, into a tobacco-pipe, and moisten it with two or three drops of tincture of iodine, and let the patient inhale the air through the pipe as if smoking. This may be repeated several times a day.

Regarding whooping-cough, the Director of the Parisian Gas Company has announced what he considers an infallible cure for that affection. It consists in the inhalation of the various complex gases generated by the distillation of coal. He states that by this means hundreds of children have been cured in his establishment, after being only once exposed to the fumes above alluded to. As it may not always be possible to take patients to the gas-works, some means might be devised for giving them the benefit of this discovery at home. W. N. Côte.

Army and Navy News.

CIRCULARS AND GENERAL ORDERS.

Disqualifications for Military Service.

(Circular No. 100.) War Department, Provost-Marshal-General's Office, Washington, Nov. 9, 1863. Paragraph 85 of the Regulations for the government of the Bureau of the Provost-Marshal-General of the United States is amended to read as follows:

85. The following diseases and infirmities are those which disqualify for military service, and for which only drafted men are to be "rejected as physically or mentally unfit for the service," viz.:

1. Manifest imbecility.
2. Insanity. This includes well established, recent insanity, with liability to a recurrence.
3. Epilepsy. For this disability the statement of the drafted man is insufficient, and the fact must be established by the duly-attested affidavit of a physician in good standing, who has attended him in the disease within the six months immediately preceding his examination by the Board.
4. Paralysis, general or of one limb, or chorea; their existence to be adequately determined. Decided atrophy of a limb.
5. Acute or organic diseases of the brain or spinal cord; of the heart or lungs; of the liver or spleen; of the kidneys or bladder, which have so seriously impaired his general health as to leave no doubt of the man's incapacity for military service.
6. Confirmed consumption. Incipient consumption does not exempt.
7. Cancer; aneurism of the large arteries.
8. Inveterate and extensive disease of the skin, such as will necessarily impair his efficiency as a soldier.
9. Decided feebleness of constitution, or deficient size of chest, sufficient in degree to leave no doubt of the man's unfitness for military service.
10. Scrofula, or constitutional syphilis, which has so seriously impaired his general health as to leave

no doubt of the man's incapacity for military service.

11. Habitual and confirmed intemperance, or solitary vice, which has so materially enfeebled the constitution as to leave no doubt of the man's incapacity for military service.

12. Chronic rheumatism, unless manifested by positive change of structure, wasting of the affected limb, or puffiness or distortion of the joints, does not exempt. Impaired motion of joints and contraction of the limbs alleged to arise from rheumatism, and in which the nutrition of the limb is not manifestly impaired, are to be proved by examination while in a state of anæsthesia induced by ether only.

13. Pain, whether simulating headache, neuralgia in any of its forms, rheumatism, lumbago, or affections of the muscles, bones, or joints, is a symptom of disease so easily pretended that it is not to be admitted as a cause for exemption unless accompanied with manifest derangement of the general health, wasting of a limb, or other positive sign of disqualifying local disease.

14. Great injuries or diseases of the skull, occasioning impairment of the intellectual faculties, epilepsy, or other manifest nervous or spasmodic symptoms.

15. Total loss of sight; total loss of sight of right eye; cataract of right eye; loss of crystalline lens of right eye.

16. Partial loss of sight of both eyes, vision being so greatly impaired as to leave no doubt of the man's inability to perform military duty. Serious permanent diseases of the eye or eyelids, so manifestly affecting the use of the eyes as to leave no doubt of the man's incapacity for military service. Nearsightedness does not exempt; if found on trial to be so decided as to incapacitate for field service, the man may be transferred to the Invalid Corps.

17. Total loss of nose: deformity of nose so great as seriously to obstruct respiration; ozæna, dependent on caries in progress.

18. Decided deafness. This disability must not be admitted on the mere statement of the drafted man, but must be proved by the existence of positive disease, or by other satisfactory evidence; and it must be so decided as to leave no doubt of the man's unfitness for military service. Chronic, purulent otorrhœa.

19. Incurable diseases or deformities of either jaw, such as will necessarily greatly impede mastication or speech. Anchylosis of the lower jaw; caries of the bones of the face, if in progress; cleft palate, (bony;) extensive loss of substance of the cheeks, or salivary fistula.

20. Dumbness; permanent loss of voice; not to be admitted without clear and satisfactory proof.

21. Total loss of tongue; hypertrophy, atrophy, mutilation, or obstinate chronic ulceration of the tongue, if sufficient in degree to interfere seriously with the use of the organ.

22. Stammering, if excessive and confirmed; to be established by satisfactory evidence under oath.

23. Loss of a sufficient number of teeth to prevent mastication of food. This applies to those cases only where the loss of teeth is so great, that if the man were restricted to solid food, he would soon become incapacitated for military service.

24. Tumors or wounds of the neck, impeding respiration or deglutition; fistula of larynx or trachea; torticollis, if of long standing and well marked.

25. Deformity of the chest, or excessive curvature of the spine, sufficient to prevent the carrying of arms and military equipments; caries of the spine, ribs, or sternum.

26. Abdomen grossly protuberant; excessive obesity.

27. Hernia.

28. Artificial anus; stricture of the rectum; prolapsus ani. Fistula in ano is not a positive disqualification, but may be so, if extensive or complicated with visceral disease.

29. Old and ulcerated internal hæmorrhoids, if in degree sufficient to impair the man's efficiency. External hæmorrhoids are no cause for exemption.

30. Total loss or nearly total loss of penis; epispadia or hypospadia at the middle or near the root of the penis.

31. Incurable, permanent, organic stricture of the urethra, in which the urine is passed drop by drop, or which is complicated by disease of the bladder; urinary fistula. Recent or spasmodic stricture of the urethra does not exempt.

32. Incontinence of urine, being a disease frequently feigned and of rare occurrence, is not, of itself, a cause for exemption. Stone in the bladder, ascertained by the introduction of the metallic catheter, is a positive disqualification.

33. Loss or complete atrophy of both testicles from any cause; permanent retention of one or both testicles within the inguinal canal; but voluntary retraction does not exempt.

34. Confirmed or malignant sarcocele; hydrocele, if complicated with organic disease of the testicle. Varicocele is not, in itself, disqualifying.

35. Loss of an arm, forearm, hand, thigh, leg, or foot.

36. Wounds, muscular or cutaneous contractions from wounds or burns, or tumors, which would prevent marching, or otherwise manifestly incapacitate the man for military service.

37. Fractures, irreducible dislocations or anchylosis of the large joints, or chronic diseases of the joints or bones, that would prevent marching, or otherwise unfit the man for military service.

38. Total loss of a thumb; total loss of the index finger of the right hand. Other permanent defects or deformities of the hands, so decided as to leave no doubt of the man's incapacity for military service.

39. Club feet; total loss of a great toe. Other permanent defects or deformities of the feet, such as will necessarily prevent marching.

40. Varicose veins of inferior extremities, if large and numerous, and accompanied with chronic swellings or ulcerations.

41. Chronic ulcers; extensive, deep, and adherent cicatrices of lower extremities.

Surgeons of Boards of Enrollment in reporting "the statistics of the causes of exemption on account of physical disability" will hereafter, in addition to the alphabetical list of disabilities required by Circular No. 90, from this office, report the number rejected under each paragraph of the above list of disqualifying infirmities.

JAMES B. FRY,
Provost-Marshal-General.

War Department, Provost-Marshal-General's Office, Washington, D. C., Nov. 16, 1863. The following changes and appointments are announced, having been made by the President of the United States, in accordance with the provisions of the "Act for enrolling and calling out the National Forces," &c., approved March 3d, 1863:

New York.—September 15, Dr. Hollis S. Chubbuck, Surgeon 27th District, vice Graves, dismissed; Nov. 11, Dr. Alfred L. Loomis, Surgeon 5th District, vice Powell, revoked.

Illinois.—September 30, Dr. Robert Boal, Surgeon 6th District, vice Hall, resigned; Nov. 2, Dr. Sam'l McClure, Surgeon 11th District, vice Payne, resigned.

Pennsylvania.—October 20, Dr. Jas. S. De Benneville, Surgeon 1st District, vice Massolis, revoked.

Massachusetts.—November 2, Dr. Fred. H. Hooper, Surgeon 1st District, vice Foster Hooper, resigned.

Michigan.—November 9, Dr. Isaac Paddock, Surgeon 5th District, vice Galbraith, revoked.

JAMES B. FRY,
Provost-Marshal-General.

Circular. Surgeon General's Office, Washington, D. C., November 12th, 1863.—Medical Directors of Military Departments will immediately furnish this office with a list of medical officers of the regular U. S. Army, and of Surgeons and Assistant-Surgeons of the volunteer staff, in their respective departments, who have been on duty in General Hospitals for more than one year.

Medical Directors of armies in the field, will immediately furnish this office with a list of medical officers of the regular U. S. Army, and Surgeons and Assistant-Surgeons of the Volunteer Staff, who have been on duty in the field for more than one year.

Both lists will give the length of service in either position, with such special information, or recommendation as may be useful in reassignments, according to nature, and length of service.

By order of the Acting Surgeon General.

[SIGNED.] C. H. CRANE,
Surgeon U. S. Army.

General Orders, No. 355, War Department, Adjutant General's Office, Washington, November 4, 1863. —Medical Directors of armies in the field will forward, direct to the Surgeon General, at Washington, duplicates of their reports to their several Commanding Generals of the killed and wounded, after every engagement.

By order of the Secretary of War:

E. D. TOWNSEND,
Assistant Adjutant General.

The Surgeon-General.

Surgeon-General Hammond, U. S. A., is in Washington, D. C.

Appointments.

The following appointments have been made during the week:

Dr. James H. Thompson, Surgeon 12th Maine Vols., to be Assistant Surgeon of Volunteers.

Dr. R. H. Wevill, late Surgeon U. S. Vols., to be Surgeon 10th U. S. Colored Troops.

Dr. Chas. G. Polk, of New York, to be Assistant Surgeon 3d U. S. Colored Troops.

Dr. Ira Perry, of Massachusetts, to be Assistant Surgeon 9th U. S. Colored Troops.

Dr. Lancaster Thomas, of Quakertown, Bucks county, has been appointed Assistant Surgeon to the 2d United States Colored Infantry, stationed at Nashville, Tennessee. He was formerly a member of the Anderson Troop.

Ordered on Special Duty.

Assistant Surgeon H. M. Sprague, U. S. Army, now on leave of absence from the Army of the Tennessee, is hereby relieved from duty with that army, and will repair to New York City and relieve Surgeon Geo. Taylor, U. S. Army, as a member of the Medical Board now in session in that city, for the examination of Surgeons and Assistant Surgeons for Colored Regiments, and for such other duty as the Medical Director, Department of the East, may assign him. As soon as relieved, Surgeon Taylor will resume his duties in charge of the General Hospital at Newark, New Jersey.

Surgeon Charles Sutherland, U. S. Army, is relieved from duty as Medical Director, Department of Virginia and North Carolina, and will repair to Wilmington, Delaware, and report to the President of the Retiring Board in session there, as a member of the Board, to take the place of Surgeon Charles McCormick.

Surgeon M. Goldsmith, U. S. Vols., has been ordered by Surgeon-General Hammond to visit the General Hospitals at New York, Baltimore, Philadelphia and Washington, with a view to collect material for his report on Hospital Gangrene, which has been so successfully treated by Surgeon Goldsmith in the hospitals at Louisville, Ky.

Ordered to Report.

Assistant Surgeon C. B. White, U. S. Vols., will report in person, without delay, to the Commanding General, Department of the Gulf, at New Orleans, La., for duty.

Assistant Surgeon E. D. Buckman, U. S. Vols., will report in person, without delay, to the Commanding Officer, Department of the South, at Hilton Head, S. C., for duty.

Assistant Surgeon L. R. Stone, U. S. Vols., will report in person, without delay, to the Commanding General, Department of West Virginia, at Clarksburg, Va., for duty.

Assistant Surgeon C. F. Brisbane, U. S. Vols., will report in person, without delay, to the Commanding General, Army of the Potomac, for duty.

Changes.

So much of Special Orders 406, Sept. 6th, 1863, from the Adjutant-General's Office, as discharged Assistant Surgeon Horace Babcock, 2d Kentucky Vols., on account of physical disability, and for absence without leave, has been so amended as to omit the charge of absence without leave, he having furnished satisfactory evidence that he was absent with proper authority.

So much of Special Orders 468, Oct. 19th, 1863, from the Adjutant-General's Office, as assigned Assistant Surgeon R. Fletcher, U. S. Vols., to duty in the Department of the Ohio, is hereby revoked, and Surgeon Fletcher will report in person, without delay, to the Commanding General, Army of the Cumberland, for duty as Medical Purveyor at Nashville, Tennessee.

Surgeon Charles McCormick, U. S. Army, is relieved as a member of the Retiring Board in session at Wilmington, Delaware, and assigned to duty as Medical Director of the Department of Virginia and North Carolina, to the commanding officer of which he will accordingly report in person.

Surgeon Thomas Antisell, U. S. Vols., will at once relieve Surgeon Thomas H. Bache, U. S. Vols., as President of the Examining Board for Assistant Surgeons of Volunteers, now in session in this city, and as Attending Surgeon to sick and wounded volunteer officers.

Surgeon Thomas H. Bache, U. S. Vols., as soon as relieved from duty in this city, will proceed, without delay, to Baltimore, Md., and report in person to the Commanding General, Middle Department, to relieve Surgeon George Rex, U. S. Vols., in charge of the General Hospital, West's Buildings, Baltimore, Md.

Surgeon Geo. Rex, U. S. Vols., as soon as relieved from duty in Baltimore, Md., will report in person, without delay, to the Commanding General, Department of the Susquehanna, to relieve Surgeon Ebenezer Swift, U. S. Army, in charge of the General Hospital at Chester, Pa.

Surgeon James D. Strawbridge, U. S. Vols., will repair at once to Annapolis, Md., and report to Brig.-Gen. Graham, U. S. Vols., senior officer of the Board convened by Special Orders 294, Adjutant-General's Office, for the examination of sick officers.

Assistant Surgeon Thomas McMillen, U. S. Army, has been relieved from duty in the Army of the Potomac, and will report in person, without delay, to the Surgeon-General, U. S. Army, at Washington, D. C., to settle up his accounts as Medical Purveyor of the Army of the Potomac.

Surgeon J. H. Taylor, U. S. Vols., has been relieved from duty as Medical Inspector of the Army of the Potomac, and will report in person, without delay, to Surgeon John Campbell, U. S. Army, Medical Director at Philadelphia, Pa., for duty in that city.

Retired.

Assistant Surgeon Benjamin King, U. S. A., has been retired from active service, having been connected with the army more than forty-five years.

Leave of Absence.

Leave of absence for twelve days has been granted to Acting Assistant Surgeon J. C. Shimer, U. S. Army.

Resignations.

Surgeon John L. Teed, U. S. Vols., and Assistant Surgeon E. T. Whittingham, U. S. Army, have tendered their resignations.

Discharges.

Assistant Surgeon W. T. Hicks, 7th Virginia Vols., having tendered his resignation on account of not being a graduate of medicine, is hereby discharged from the service of the United States, with condition that he shall receive no final payments until he has satisfied the Pay Department that he is not indebted to the Government.

At the request of the Governor of Maryland, Surgeon John M. Stevenson, 3d Maryland Vols., has been honorably discharged from the service of the United States, he having been commissioned by the Governor as Surgeon of a Regiment of Maryland Cavalry.

Upon the recommendation of a Board of Officers, convened by Special Orders 294, July 3, 1863, from the Adjutant-General's Office, Assistant Surgeon Edson Boyd, 112th New York Vols., is honorably discharged from the service of the United States on account of physical disability, with condition that he shall receive no final payments until he has satisfied the Pay Department that he is not indebted to the Government.

The following officers, having tendered their resignations, are honorably discharged from the service of the United States on account of physical disability, with condition that they shall receive no final payments until they have satisfied the Pay Department that they are not indebted to the Government: Surgeon Darius Mason, 31st Wisconsin Vols.; Assistant Surgeon Solomon Blood, 32d Wisconsin Vols.; Assistant Surgeon F. A. Bushey, 4th Pennsylvania Cavalry.

News and Miscellany.

Pension Examining Surgeons.

Connecticut.—Dr. Rufus Baker, Middletown.
New York.—Drs. Edward Loomis, Oneida; Rufus C. Dunham, Seneca Falls.
Ohio.—Drs. Samuel Hudson, Medina; W. J. Fishler, St. Mary's.
Indiana.—Dr. Edward V. Spencer, Mt. Vernon.

Number of Invalid Soldiers.

According to an official report in the Surgeon-General's office, there are 84,472 beds for patients in the United States General Hospitals. Of these, 36,277 are empty, leaving 48,195 patients under treatment.

Hospital Inspection.

In accordance with a special order from Major-General Couch, Surgeon John Campbell, U. S. A., Medical Director of the Department of the Susquehanna, left this city on Monday, to make a personal inspection of the army hospitals in his Department.

Surgeon Rufus H. Gilbert, U. S. A., formerly Medical Director of the Department of Virginia, stationed at Fortress Monroe, has been appointed Acting Medical Director of this Department, to serve during the absence of Surgeon Campbell, from Philadelphia.

Unwholesome and Innutritious Bread.

Mr. D. Pearson, in a note to the *Scientific American*, has some very proper strictures on the manufacture of bread. He commends the bread of London and Edinburgh. We, however, published an item a few weeks ago, showing that an inspection of the bakeries of London brought to light the fact that they were managed in a manner so exceptionable as to raise a question of the fitness of the bread for food.

Our own experience is decidedly in favor of the ærated bread, which is *always and necessarily* sweet, pure, and wholesome. It is complained of by some, that it is tasteless. Better so, than sour and impure. But the manufacturers, we think, might easily obviate that difficulty by the addition of a little sugar. We have no doubt that the experiment would prove a profitable one. That much might be conceded to popular *taste and prejudice*.

Mr. Pearson speaks as follows of New York bakers' bread:

During a residence of over ten years in the city, I have had occasion to use the bread of perhaps thirty or fifty bakers, and as a general thing I have found that the only perceptible difference between that of one and another, lay in the various degrees of sourness and badness generally possessed by the whole. Saltness, bitterness, and other incomprehensible and nauseous flavors would occasionally supersede or accompany other defects, but sourness in greater or less degree was a perpetual concomitant. The other disagreeable flavors in the bread I am speaking of, I supposed to be indicative of the presence of carbonate of soda, or some other "corrective" of acidity; and if this supposition is correct, of course the quality of the article would be still more depreciated.

Now the main cause of all this I take to be nothing else than the absurd custom of bakers giving their customers *bulk* instead of *weight* of bread. Many a poor woman is foolish enough to believe that the large-sized loaf which she procures from Mr. Swill's bakery, though perhaps as sour as vinegar, is a much better bargain than those slightly smaller ones sold at Mr. Sugar's, 'round the corner; the latter, it may be, being two or three ounces heavier than the former. But human nature is gullible, and thus it is that the favorite divices seen on bakers' sign-boards in New York read thus—"*Large* Bread Bakery," "The Largest Bread in the City," &c. The *large* bread in question I have found by experience means simply *sour* bread; for it is a well known fact that up to a certain point in the chemical process in the fermentation of bread, the *sourer* the dough is allowed to become the *larger* will be the bread baked from it. The writer has ransacked a large section of the city in quest of sweet bread (that is, good bread), and like truth itself, sometimes, he found it was nowhere to be found. I have tried different bakers, and the result has been that I have found one or two places where sometimes I could procure really good, sweet bread; whilst in none of the others is it ever by any chance to be had. This circumstance would seem to show that the very great majority of bakers ferment their bread to the point of acidity designedly, for the purpose, of course, of giving as little weight and as much bulk as possible for the money. It is clear, therefore, that if by law or custom it became the rule to sell by weight only, the above evil would cease at once.

Electrical Phenomena in the Alps.

A party consisting of three Englishmen and a lady, with two guides, endeavored to make the ascent of the Alps on the 10th of July last, but when they had proceeded some distance they were prevented by a storm, during which they got into the middle of an electric cloud. Their hair emitted a hissing, crackling sound, as if it had been under the influence of a powerful electrical machine, and over their faces and bodies they experienced a pricking, burning sensation. There were peals of thunder heard, at each of which the party received an electric shock, but no lightning was seen. The right arm of one of the party was paralyzed for several minutes; the snow emitted hissing sounds; the veil worn by the lady stood straight out, as also did the hair of all of them; which looked so ludicrous that they could not help bursting into laughter. These phenomena lasted for about twenty-five minutes, and no evil effects were felt afterwards.—*Scientific American.*

Sugar as an Anthelmintic.

M. Debout says that sugar is an excellent destroyer of worms. He once accidentally put sugar instead of salt on a leech which he wished to detach from the skin, and was surprised at the spasms produced by it. He therefore tried sugar on earth-worms, and found it had a similar powerful effect; and has since used it in solution with success as an injection in children.—*Brit. Med. Jour.*

ANSWERS TO CORRESPONDENTS.

☞ *Correspondents will please notice our reiterated request to give their full address in their communications to us. Our correspondence is very extensive, and it is necessary for us always to know the Town, County and* State *from whence their letters are sent.*

Erratum.—In the last number of the Reporter, page 396, at the end of the Communication, the signature should be "Lloyd Dorsey, M. D.," instead of "Doorey."

Dr. F. M. C., Mass.—We would advise you to address the Journal in question in regard to your subscription to it. We cannot aid you in the matter.

Dr. G. S. W., Pa—We have received no letter from you since October 27th, enclosing $3.

Dr. H. C, Pa.—Your letter came to hand, but there was no check for $6 enclosed therein. We enclose you a statement of account and some vaccine matter.

Dr. J. H. C., Mass.—Vols. 1, 2, 3, 4, 5, of the Reporter unbound and Barclay's Medical Diagnosis, were forwarded to you on last Saturday per Harnden's Express.

MARRIED.

Bradford—Gunnell.—On Wednesday, the 11th instant, by the Rev. Dr. Pinckney, Dr. Frederick G. H. Bradford, of Maine, and May, daughter of W. H. Gunnell, Esq., of this city.

Evans—Richards.—On Tuesday, the 10th instant, by the Rev. John M. Richards, D. D., Horace Y. Evans, M. D., and Anna L., youngest daughter of the late William H. Richards, both of this city.

French—Bailey.—On Thursday, November 12th, by Rev. J. H. Price, D. D., T. Jefferson French, and Helen A., eldest daughter of M. J. Bailey, M. D., all of New York.

Hoppin—Clark.—In Dedham, Mass., 12th inst., by Rev. S. B. Babcock, Courtland Hoppin, M. D., of Providence, and Mary Frances, daughter of Joseph W. Clark, of Dedham.

Swann—Lyon.—In Charlestown, Mass., the 10th instant, Lieut. Thomas L. Swann, U. S. Navy, and Elizabeth, daughter of Dr. Henry Lyon.

DIED.

Elmer.—At Springfield, N. J., on the 8th inst., of inflammation of the bowels, William Stites, only son of the late Dr. John C. Elmer, aged 17 years.

METEOROLOGY.

November	9,	10,	11,	12,	13,	14,	15.
Wind.....	N. W.	N.	N. W.	S. W.	W.	N. E.	S. E.
Weather.....	Clear.	Clear. Slight Snow.	Clear.	Clear.	Clear.	Cl'dy. Dense Fog.	Cl'dy. Rain.
Depth Rain...							8-10
Thermometer							
Minimum.....	28°	24°	26°	28°	39°	41°	43°
At 8 A. M.....	33	33	38	45	45	45	56
At 12 M.....	42	40	45	59	58	64	62
At 3 P. M.....	42	39	46	59	59	64	61
Mean.....	36.2	39	38.7	47.2	50.2	53.5	55.5
Barometer.							
At 12 M.....	30.1	30.3	30.2	30	30	30	29.7

Germantown, Pa. B. J. Leedom.

VITAL STATISTICS.

	Philadelphia. Week ending November 16.	New York. Week ending November 16.	Baltimore. Week ending November 16.	Boston. Week ending November 14.	Providence. Month of October.
Popl'n, (estimated.)	580,000	960,000	240,000	180,000	52,000
Mortality.					
Male	136	235	70	42	38
Female	116	218	41	46	49
Adults	134	222	50	48	51
Under 15 years	113	230	61	41	34
Under 2 years	66	134	31	34*	19
Total	252	453	111	88	87
Deaths in 100,000	43.46	47.68	46.25	48.88	16.73
American	178	274	...	51	64
Foreign	57	179	...	37	23
Negro	16	9	21	3	4
Zymotic Diseases.					
Cholera, Asiatic	...	...	...	...	...
Cholera Infantum	4	3	...	2	...
Cholera Morbus	...	1	...	...	3
Croup	15	31	7	8	...
Diarrhœa	5	11	4	1	4
Diphtheria	15	22	4	2	1
Dysentery	1	4	...	...	4
Erysipelas	1	1	...	1	...
Fever, Intermittent	...	1	...	...	...
Fever, Remittent	1	...	...	...	...
Fever, Scarlet	3	19	5	...	...
Fever, Typhoid	12	13	5	3	4
Fever, Typhus	1	5	...	...	...
Fever, Yellow	...	...	...	...	...
Hooping-cough	...	2	1	...	1
Influenza	...	...	...	...	...
Measles	...	...	...	...	...
Small Pox	...	...	9	...	...
Syphilis	1	...	...	1	...
Thrush	...	..	...	1	...
Sporadic Diseases					
Albuminuria	...	4	...	...	...
Apoplexy	3	...	...	1	1
Consumption	32	81	13	16	18
Convulsions	8	24	4	3	2
Dropsy	5	23	3	4	3
Gun-shot Wounds	2	1	1	...	...
Intemperance	2	1	2	1	...
Marasmus	1	17	...	...	...
Pleurisy	...	2	1	1	...
Pneumonia	8	34	2	5	3
Puerperal Fever	...	3	...	...	...
Scrofula	...	1	...	...	...
Violence and Acc'ts	5	24	1	...	2

* Under 5 years.

TO CORRESPONDENTS.

For the information of those who are not authors, we will state that manuscript intended for publication must be written on but one side of the sheet. If greater care was taken in the preparation of copy, much trouble would be saved to printers, and mistakes would rarely or never be made.

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(List to be continued.)

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(See also the Commutations in another place.) 357—tf

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"	and Physicians' Hand-Book of Practice for 1864. Townsend, N. Y. The name stamped on tuck in gilt letters	3 85	4 25
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